Other Insurer Tool

Part I

1. Are you receiving Black Lung (BL) Benefits?

___ yes: Date benefits began: _____
BL is primary only for claims related to BL
___ no

2. Are the services to be paid by a government program such as a research grant?

___ yes: The government program will pay primary benefits for these services.
___ no

3. Has the Department of Veteran Affairs (VA) authorized and agreed to pay for care at this facility?

___ yes: VA is primary for these services.
___ no

4. Was the illness/injury due to a work-related accident/condition?

___ yes: Date of injury/illness: _____

Name and address of workers' compensation (WC) plan:
_____
_____
_____

Policy or identification number: _____

Name and address of your employer:
_____
_____
_____

WC is primary payer only for claims related to work-related injuries or illness. **GO TO PART III.**

___ no. **GO TO PART II.**

Part II

1. Was illness/injury due to a non-work-related accident?

___ yes: Date of accident: _____ _____
___ no. **GO TO PART III.**

2. What type of accident caused the illness/injury?

___ automobile

___ non-automobile

Name and address of no-fault or liability insurer:

_____
_____
_____

Insurance claim number: _____

No-fault insurer is primary payer only for those claims related to the accident. **GO TO PART III.**

___ other

3. Was another party responsible for this accident?

___ yes:

Name and address of any liability insurer

_____
_____
_____

Insurance claim number: _____

The liability insurer is primary only for those claims related to the accident. **GO TO PART III**.

___ no. **GO TO PART III.**

Part III

1. Are you entitled to Medicare based on:

___Age. **GO TO PART IV.**
___ Disability. **GO TO PART V.**
___ ESRD. **GO TO PART VI.**

Part IV - Age

Are you currently employed?

___ yes:

Name and address of your employer:

_____
_____
_____

___ no: Date of retirement: _____

2. Is your spouse currently employed?

___ yes:
Name and address of spouse's employer:
_____
_____
_____

___ no: Date of retirement: _____

If the patient answered no to both questions 1 and 2, Medicare is primary unless the patient answered yes to questions in part I or II. **STOP. DO NOT PROCEED ANY FURTHER.**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

___ yes;
___ no. **STOP**. Medicare is primary payer unless the patient answered yes to the questions in part I or II.

4. Does the employer that sponsors your GHP employ 20 or more employees?

___ yes. **STOP**. The GHP is primary. Obtain the following information:

Name and address of GHP:
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to patient: _____

___ no. **STOP.** Medicare is primary payer unless the patient answered yes to questions in part I or II.

Part V – Disability

1. Are you currently employed?

___ yes:
Name and address of your employer:

_____
_____
_____

___ no:
Date of retirement: _____

2. Is a family member currently employed?

___ yes:
Name and address of employer:
_____
_____
_____

___ no.

If the patient answers no to both questions 1 and 2, Medicare is primary unless the patient answered yes to questions in part I or II. **STOP. DO NOT PROCEED ANY FURTHER.**

3. Do you have GHP coverage based on your own or a family member's current employment?

___ yes.
___ no. **STOP**. Medicare is primary unless the patient answered yes to questions in part I or II.

4. Does the employer that sponsors your GHP employ 100 or more employees?

___ yes. **STOP**. The GHP is primary. Obtain the following information:
Name and address of GHP:
_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to the patient: _____

___ no. **STOP**. Medicare is primary unless the patient answered yes to questions in part I or II.

PART VI – ESRD

1. Do you have GHP coverage?

___ yes:
Name and address of GHP:

_____
_____
_____

Policy identification number: _____

Group identification number: _____

Name of policyholder: _____

Relationship to the patient: _____

Name and address of employer, if any, from which you receive GHP coverage:
_____
_____
_____

___ no. **STOP**. Medicare is primary.

2. Have you received a kidney transplant?

___ yes:
Date of transplant: _____
___ no.

3. Have you received maintenance dialysis treatments?

___ yes: Date dialysis began: _____

If you participated in a self-dialysis-training program, provide date training started:
_____ _____

___ no.

4. Are you within the 30-month coordination period?

___ yes.
___ no. **STOP**. Medicare is primary.

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

___ yes.
___ no. **STOP**. The group health plan (GHP) is primary during the 30-month coordination period.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

___ yes**. STOP**. The GHP continues to pay primary during the 30-month coordination period.
___ no. Initial entitlement is based on age or disability.

7. Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)?

___ yes. The GHP continues to pay primary during the 30-month coordination period.
___ no. Medicare continues to pay primary.